## **PATIENT SCREENING FORM**

I. Has it been more than a year since you completed a "How's Your Health"  Survey (HYH)  2. Primary Language: 3. Are you experiencing pain at this time? 4. Do you need any educational information today?  5. What method(s) of learning do you prefer? (Select all that apply)  □ One-on-One Instruction □ Group Instruction □ Reading □ Videos □ Demonstration □ Other: 6. Do you have any medical problems that make it difficult for you to understand medical information or instructions?  7. Learning Barriers: (Select all that apply) □ Hearing □ Vision □ Speech □ Cultural □ Motivation □ Religious □ None □ Other: 8. Do you have any religious customs, beliefs or rituals that may affect your medical care? 9. Are you taking any dietary supplements, herbal medications or vitamins?  10. Have you experienced a 10-pound or more change in weight in the past 6 months?  11. Do you have a medical problem that effects what you can eat?  12. Do you have a medical problem that effects what you can eat?  12. Do you have any problems performing your activities of daily living?  (Activities such as dressing, feeding, grooming or bathing yourself or walking)  SIGNATURE OF PATIENT:  PATIENT, PLEASE RECHECK & COMPLETE WITH EACH VISIT  Has Your Information on This Form Changed Since Your Last Visit?  Select ONE  YES Information Has Changed  No Information Has Not Changed  PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name – last, first, middle, 1D No. or SSN; Sev; Date of Birth; Rank/Grade.)  WRAMC FORM 716  Jul 10 2		ES OR NO COLUMN AND UPDATE		YES	NO
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